THE RECOVERY KERNEL

How to Navigate the Recovery Kernel

For People Recovering from PCP

Phencyclidine ("wet," "sherm," "angel dust," "embalming fluid"). A step-by-step route: what to read, in what order, and what to expect. Written for the person recovering and for the people who may have to respond to an emergency.

> **HARM REDUCTION RESOURCE — NOT MEDICAL ADVICE. PCP INTOXICATION IS A MEDICAL EMERGENCY. CALL 911 FIRST.** The Kernel's picture: eyes that cannot hold still (nystagmus, the most reliable sign), no response to pain, extreme agitation with apparent strength, and confusion or psychosis. Tell the dispatcher "PCP, phencyclidine, with agitation and apparent psychosis." **Do not try to restrain the person forcefully:** the surge from restraint can cause overheating and cardiac arrest, and it has caused deaths. Reduce noise and light, speak slowly and quietly from a distance, and move them away from traffic, water, heights, and heat, because without pain they can be badly injured without noticing. Very hot skin with no sweating needs cooling and 911.
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> **If psychosis has not substantially cleared within 48 hours of the last use, get a psychiatric evaluation.** PCP psychosis can last days to weeks. It is a medical condition, not "still being high," and each untreated day carries its own risks. Tell clinicians it is PCP-induced.
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> Crisis: call or text 988 · SAMHSA: 1-800-662-4357 · Crisis Text Line: text HOME to 741741

1. Before you start

This is a route through the Recovery Kernel for people whose use of PCP has become a problem, and for the family, friends, and clinicians around them. The Kernel calls PCP the most pharmacologically complex substance in the series, because it acts on four systems at once: a very potent NMDA blocker (dissociation and pain insensitivity, like ketamine but more potent and much slower to leave the receptor), a dopamine reuptake inhibitor (stimulant arousal and agitation, which ketamine lacks), a sigma-1 agonist (perceptual alteration, like DXM), and a muscarinic anticholinergic (dry mouth, fast heart, poor sweating, confusion, memory effects). That combination of dissociation with stimulation is what produces its distinctive and dangerous behavior, and the Kernel says the person who used it was not the person the public saw. Six rules follow.

- **Psychosis is the medical priority.** Prolonged PCP psychosis needs psychiatric care, and the psychiatrist needs to know it is PCP-induced.
- **Never restrain forcefully, never talk down.** Sensory reduction, distance, safety, and 911. The Kernel says the "talk-down" that works for psychedelics does not work for PCP.
- **Know your CYP2B6.** The Kernel calls it the "Dissociative Logjam" gene: a poor metabolizer may clear PCP slowly, with longer, deeper effects and longer psychosis.

- **PCP is stored in fat.** The Kernel says it can be released weeks later, especially with exercise, fasting, or illness, and re-emerge as symptoms.
- **Two things were sought, and sometimes a third.** Recovery builds a dissociative-escape practice and a stimulant-intensity outlet, and repairs the memory and attention systems the anticholinergic effect hit.
- **Do not wait for test results to start.** The genome refines the plan (Main Book, Quick-Start Step 3; Supp. Ch. 5, Step 1b), but psychiatric safety comes first.

How chapters are cited. "Main Book" is the Recovery Kernel Main Book (Second Edition, Centurian). "Compendium" is the Complete Protocol Compendium. "Supp. Ch. N" is chapter N of the Supplemental Book. The core chapter is Chapter 25 (How to Recover from PCP), which builds on the ketamine (Ch. 23), DXM (Ch. 24), cocaine (Ch. 12), and crack (Ch. 13) chapters. Section numbers (§) refer to sections inside those chapters.

> **A note on protocol numbers.** Supplemental Chapter 25 cites Compendium protocols by number, and some numbers do not match the Compendium as printed. It sends the sleep and foundation phase to Protocols 07, 09, and 17 (Protocol 09 is printed as The Gut-Brain Axis; sleep is Protocol 17), and it cites a "C-37" substance-masking analysis (the Compendium prints Protocol 37, Substance Masking Analysis) and a "C-28" masking analysis (Centurian Paper C-28 is The Recast). It also sends genomic mapping to "Section 15 (Compendium)" and refers to a dissociative "sonic protocol" without a number. This guide cites each protocol by its printed title. If a number and a title disagree, follow the title.
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> For PCP, there is no reliable way to judge “was that enough” from the inside — its own effects actively prevent good self-assessment, so there is no dose to safely chase.
>
> Redosing is not the only version of this. Watching peers in a treatment setting negotiate a relapse, getting confident advice from someone untrained in your specific situation, or noticing a prescriber treat a prescribed substance more casually than an illicit one can all trigger the same pattern: a felt doubt read as “the plan must be wrong,” answered by abandoning it. See **The Commandeering Map**, a companion to this series, for the fuller pattern, including how it can differ by genetic profile and what helps when practice-based resistance alone is not enough.

2. The route at a glance

Steps 0 and 1 come first and cannot be skipped. Steps 2 to 4 can run at the same time. Steps 5 to 9 overlap and are the work of the first year. Step 10 is everything after. "P" means Compendium Protocol; "C" means Centurian Paper.

Step	When	What you do	Turn to
0	Day 0	Triage: the intoxication emergency, what "wet" may contain, and the psychosis warning.	Supp. Ch. 25 §0 Main Book, Quick-Start Step 1 Compendium P01
1	Days 0–14	Psychiatric care for prolonged psychosis. Sleep. Watch temperature and heart.	Supp. Ch. 25 §0.3, §3, §7

Step	When	What you do	Turn to
2	Weeks 1–4	Read the Main Book in order.	Main Book: Who This Book Is For, Quick-Start, Part One (Ch. 1–5) Supp. Ch. 2, 3
3	Weeks 1–4	Order 30× whole-genome sequencing. CYP2B6 is the priority.	Supp. Ch. 5 Step 1 Supp. Ch. 25 §2 Compendium P06
4	Weeks 2–6	Resolve your profile. Work out which of the four functions you sought.	Supp. Ch. 5 Steps 2–3, 6 Supp. Ch. 25 §1.4, §2
5	Day 1 to Month 6	Build the triple foundation: NMDA, dopamine, acetylcholine, on a methylation base.	Supp. Ch. 25 §4 Supp. Ch. 5 Phase One Compendium P07, P17
6	Weeks 1–12, then ongoing	The dual craving: intensity first, breath second. Cues, pain, and residue.	Supp. Ch. 25 §5 Compendium P05, P08, P21
7	Months 1–12	Build the dual natural architecture, plus the memory and attention track.	Supp. Ch. 25 §6 Supp. Ch. 23 §6; Ch. 12 §6 C-28; Compendium P19
8	From week 1	Co-occurring conditions and the physician conversation. Nicotine and bupropion.	Supp. Ch. 25 §3.2–3.3, §8.2 Compendium P13
9	Months 1–12+	The community and structural picture: peer recovery, legal, and economic.	Supp. Ch. 25 §8.1 Supp. Ch. 13 §8; Ch. 42, 43 Compendium P22, P24
10	Months 6+, Year 1 to 10	Cognitive recovery, identity, and stewardship.	Supp. Ch. 25 §7 Supp. Ch. 44, 6, 38 Compendium C-28, P25

3. The route, step by step

Step 0 — Triage (Day 0, before everything)

For a helper: the four signs together point to PCP. Eyes moving involuntarily and unable to fix on a point; little or no response to pain, so serious burns, cuts, or fractures can go unnoticed; agitation, restlessness, and apparent extra strength (unlike ketamine or DXM, which usually sedate); and profound confusion, hallucination, or paranoid terror. The Kernel's emergency order: call 911 first and name the substance; lower stimulation (dim, quiet, no touching, slow and low speech from a distance); make the space safe from traffic, water, heights, and hot surfaces; leave sedation to the clinicians, who it says use benzodiazepines rather than physical restraint and avoid some antipsychotics because of seizure risk; and watch temperature, since overheating from stimulant demand, poor sweating, and agitation is a main cause of death.

What "wet" can contain. It is usually a cigarette dipped in a liquid, with PCP sometimes dissolved in a solvent that may include actual embalming fluid, which adds lung and body toxicity. The strength is unpredictable, and what is sold may contain ketamine, PCP analogs, or no PCP at all. The Kernel says there is no reliable field test for concentration.

Turn to: Supp. Ch. 25 §0 (recognizing intoxication; the emergency response; the prolonged psychosis warning; what is in "wet"). Main Book, Quick-Start Boot Sequence, Step 1. Compendium Protocol 01, Emergency Triage, for an acute crisis state.

Step 1 — Psychiatric care first (Days 0–14)

The Kernel says this is the one dissociative where recovery has a medical dimension from the start. PCP psychosis is the closest known pharmacological model of schizophrenia because it produces both positive symptoms (hallucinations, delusions) and negative ones (emotional blunting, withdrawal, poor motivation), and it can meet criteria for a psychotic disorder while it lasts. Its guidance for the clinical side: in the first hours, benzodiazepines and a low-stimulation room, with sleep as the most powerful non-drug intervention; for psychosis beyond about 48 hours, an atypical antipsychotic chosen and dosed by a psychiatrist; most PCP psychosis clears substantially within 2 to 6 weeks of abstinence with treatment and sleep, and a poor CYP2B6 metabolizer may take longer. If psychosis persists beyond about six weeks of full abstinence, an evaluation for an independent psychotic disorder is warranted. Tell the psychiatrist "this is PCP-induced psychosis, not primary psychosis," since treatment and prognosis differ. A first-episode psychosis in a young person with PCP use should always consider PCP as the cause, and the Kernel notes drug screens may be negative by the time of the psychiatric visit.

Persisting negative symptoms (blunting, low motivation, poor thinking) look like depression but, the Kernel says, come from dopamine receptor downregulation and prefrontal BDNF suppression, so an antidepressant alone may not help; exercise and the rebuilding steps below matter, and some people need continued antipsychotic support. Finally, PCP is stored in fat and released during exercise, fasting, or illness, so symptoms can flare unexpectedly after apparent cessation. Urine tests can stay positive for about a week in occasional users, and for a month or more in heavy users.

Turn to: Supp. Ch. 25 §0.3 (the prolonged psychosis warning), §1.3 (the PCP psychosis model), §1.5 (duration, metabolism, and the lipophilicity problem), §3 (medical management), and §7 (the protocol map). Compendium Protocol 01, Emergency Triage.

Step 2 — Read the Main Book (Weeks 1–4)

Read it in order once you are stable. If you are overwhelmed, the Quick-Start Boot Sequence is designed to be read on its own. Read "Who This Book Is — and Is Not — For" first: it names situations where the supplement protocols need medical modification, including active psychosis, pregnancy, and severe liver disease. Active psychosis matters directly here.

Read in this order: Who This Book Is For → Quick-Start Boot Sequence → Part One: Ch. 1 (Why Willpower Isn't Enough), Ch. 2 (MTHFR), Ch. 3 (COMT; the Warrior and Sage profiles both matter here), Ch. 4 (CYP450), Ch. 5 (When Systems Collide) → Part Two, the case files (Chapter 6). Ch. 8 (Oxytocin Protocol) is experimental and specialist-only. Ch. 9 (Epigenetic Playground) belongs to Steps 7 and 10. Appendix A and Appendix B are reference.

Then add: Supp. Ch. 2 (Clarity · Restoration · Manning). The Kernel has no PCP case study. The nearest are Case 09 (ketamine) and Case 04 (cocaine). Supp. Ch. 23 (Ketamine), which Chapter 25 tells you to read alongside it, and Supp. Ch. 12 and 13 (cocaine and crack) for the stimulant track. Supp. Ch. 3 (The Addict Virgin Problem) recalibrates timelines. Supp. Ch. 1 (Why They Left You There) is optional reading for the shame.

Step 3 — Get your DNA (Weeks 1–4)

The Kernel's recommended route is 30× whole-genome sequencing, which returns a VCF file, a one-time asset you keep. A consumer SNP array is an acceptable start. A clinical pharmacogenomic panel adds clinical-grade CYP calls. Homocysteine, B12, and RBC folate are functional markers you can recheck quarterly.

The Kernel calls PCP the most genetically complex recovery profile in the series. **CYP2B6** is the priority, and it says the test is the single most actionable one and one most physicians will not think to order. Next: **CYP3A4** (the main clearance pathway alongside CYP2B6; inhibitors such as fluconazole, some antibiotics, grapefruit, and some HIV drugs can slow clearance), **COMT** (Val/Val for the dopamine-intensity pull; Met/Met for the highest psychosis risk), **DRD2/ANKK1**, **MTHFR**, and **BDNF**. Until results arrive: were effects consistently stronger or longer than for others at the same amount; did psychosis or confusion last for days; was the pull mostly stimulant intensity, or mostly escape and pain relief; did PCP make you feel unusually "calm" or "right" (a possible slow-COMT finding, and also the highest psychosis-risk profile)?

> **Confirm what you are ordering.** Supp. Ch. 5 specifies 30× whole-genome sequencing with VCF output. "WGBS" more commonly names whole-genome bisulfite sequencing, a DNA-methylation assay that is not built to call variants such as MTHFR C677T. Ask the lab for a standard variant file (VCF).

Turn to: Supp. Ch. 5, Step 1. Supp. Ch. 25 §2 (the DNA testing panel for PCP recovery; phenotyping without testing). Compendium Protocol 06, Phenotype Assessment. Main Book Ch. 2 and Ch. 3 self-assessments.

Step 4 — Resolve your profile (Weeks 2–6)

Write your profile down and carry key results on a card. The Kernel's question is what PCP gave you, because it says the answer is usually two or three things at once.

If your result is...	What changes	Source
CYP2B6 *6/*6 poor metabolizer	The "Dissociative Logjam": PCP accumulates, effects deepen and last longer, and psychosis runs longer. Also affects bupropion, efavirenz, and other drugs, so tell every prescriber.	Supp. Ch. 25 §2, §3.2

If your result is...	What changes	Source
CYP3A4 inhibitors on board	Fluconazole, some antibiotics, grapefruit, and some HIV drugs can slow clearance further. Combined with poor CYP2B6, accumulation is extreme.	Supp. Ch. 25 §2
COMT Val/Val (Warrior)	The stimulant intensity was a main pull. Recovery needs a real intensity architecture alongside the escape practice.	Supp. Ch. 25 §2, §6
COMT Met/Met (Sage)	Higher baseline catecholamine tone plus PCP's dopamine and NMDA effects makes the highest psychosis-risk profile. Anxiety management and close psychiatric follow-up matter.	Supp. Ch. 25 §2
DRD2 A1	Reward deficiency: PCP's dopamine effect filled a D2 gap that chronic use then deepened. Build several reward sources.	Supp. Ch. 25 §2
MTHFR variants	5-MTHF addresses a synthesis deficit PCP was flooding past, and is often the most impactful early supplement for mood and cognition.	Supp. Ch. 25 §2, §4.1; Main Book Ch. 2
BDNF Met	PCP's prolonged NMDA blockade suppresses prefrontal BDNF more than ketamine does, so cognitive recovery may be slower. Vigorous exercise is critical.	Supp. Ch. 25 §2

Turn to: Supp. Ch. 5, Steps 2, 3, and 6 (gene systems, combined profiles, profile template). Supp. Ch. 25 §1.4 (what PCP was providing) and §2. Main Book Ch. 5 and Appendix A.

Step 5 — Build the triple foundation (Day 1 to Month 6)

The Kernel says PCP recovery runs three tracks at once on a methylation base. Methylation: 5-MTHF, methylcobalamin, active B6, and magnesium glycinate from day 1, which it calls the most immediately effective supplement for the anxiety and mental overdrive of stopping. NMDA and glutamate: NAC (its most multi-functional supplement here), L-theanine, glycine, and omega-3. Dopamine: tyrosine, a receptor-support stack (uridine, DHA, and CDP-choline), and rhodiola. Acetylcholine, the track no other guide needs: alpha-GPC, CDP-choline, lion's mane, and dietary choline, with huperzine-A only under physician guidance and not stacked at high doses. Neuroprotection: NAC, alpha-lipoic acid, and EGCG. Sleep: quetiapine, if a psychiatrist prescribes it (which the Kernel says serves sleep, anxiety, and psychosis together), then magnesium, glycine, theanine, and melatonin, with slow, warm audio and no music tied to use. The dose tables are in the chapter and belong with your clinician. Run every addition past a pharmacist and an interaction checker (Drugs.com or Medscape). The peptide layer in Supp. Ch. 25 §4.7 is not a self-start step.

> **A caution this guide adds.** The Kernel starts the dopamine track (tyrosine, rhodiola) within days. Dopamine-raising supplements are not appropriate while psychotic symptoms are active, since they could worsen them. Wait for your psychiatrist to say the psychosis has cleared before starting them, and ask before adding anything stimulating.

Turn to: Supp. Ch. 25 §4.1 (methylation), §4.2 (NMDA glutamate system normalization), §4.3 (dopaminergic system reconstruction), §4.4 (acetylcholine system support), §4.5 (neuroprotective stack), §4.6 (sleep architecture), §4.7 (peptides, physician only). Supp. Ch. 5, Phase One. Main Book Ch. 2, §2.4–2.5. Compendium Protocol 07 (Neuroplasticity), Protocol 17 (The Nightly Restoration), and Centurian Paper C-32 (The Insomnia Architecture).

Step 6 — The dual craving (Weeks 1–12, then ongoing)

The Kernel calls PCP's craving the most complex in the series, because two run together: the dissociative escape (the quiet, the disconnection, the pain relief) and the stimulant intensity. Early recovery is often both at once: the world too loud from NMDA rebound and too dull from the dopamine crash. Its triggers: the wet cues (the chemical-tinged smell of the cigarette is one of the most strongly conditioned cues in the series, so remove papers, tobacco, and materials tied to it, and handle the places where it was obtained or smoked); the flat, too-loud-and-too-dull state; pain, physical or emotional; and, unusually, residual perceptual or cognitive disturbances that can push a person toward the drug that caused them.

The interrupt, in the Kernel's order: name which craving is firing; intense physical activity first (sprints, push-ups, cold water), because the stimulant side needs a real signal before anything else works; then six cycles of 4-7-8 breathing for the rebound anxiety; your NAC, magnesium, and, once cleared, tyrosine; contact with someone outside the conditioned unit of person, place, and substance; and, for pain-driven craving, the pain plan. For residue-driven craving, name it: "this is PCP residue being metabolized. More PCP will extend it. Sleep and time are the resolution," and take any prescribed antipsychotic.

Turn to: Supp. Ch. 25 §5 (the PCP craving: the trigger map; the interrupt). Compendium Protocol 05 (Digital Detox), Protocol 08 (Social Environment), Protocol 21 (Reading the Collapse).

Step 7 — The dual natural architecture, and the memory track (Months 1–12)

The Kernel says two architectures must be built at once, plus a third. Sequence: start with the intensity track, which is quicker and more immediately rewarding, then build the contemplative track, which is slower and more durable. The intensity track: high-intensity competitive exercise with real stakes, competition in any domain, mastery at the edge of skill, and service. The escape track, from the ketamine chapter: meditation (absorption states), non-sleep deep rest (yoga nidra), nature and awe, and, if pain relief was primary, exercise-generated endorphin analgesia, physical therapy, and a proper pain plan. The memory and attention track: deliberate recall (journaling, storytelling), sustained-attention practice (long reading, chess), choline-rich foods, and learning a complex motor skill such as martial arts, dance, or an instrument. The Kernel says cognitive recovery may need the longest explicit work of any substance in the series, roughly 6 to 12 months for significant improvement after heavy use.

> **A caution this guide adds (not in the Kernel).** Hyperventilation-based breathwork can provoke panic, dissociation, or psychosis-like states, and PCP carries a very high psychosis liability. Do not try it unless your clinician clears it, and start with slow breathing, non-sleep deep rest, and meditation, which the Kernel also names.

Turn to: Supp. Ch. 25 §6 (porting the addiction: the dual natural architecture; the acetylcholine restoration architecture). Supp. Ch. 23 §6 (ketamine natural porting), Supp. Ch. 12 §6 and Ch. 13 §6 (stimulant natural architecture). Supp. Ch. 36 (Roots and Reversal). Centurian Paper C-28 (The Recast). Compendium Protocol 19 (The Body in Motion), Protocol 29 (The Peacetime Paradox).

Step 8 — Co-occurring conditions and the physician conversation (from week 1)

There is no FDA-approved medication for PCP use disorder. The Kernel lists what exists: antipsychotics for prolonged psychosis; benzodiazepines only for short-term acute anxiety and sleep, given the addiction risk; non-stimulant ADHD treatment (atomoxetine, guanfacine) if ADHD is confirmed, since the dopamine effect may have been self-medication; and careful depression treatment, telling serotonergic depression from the dopamine-driven negative symptoms, with 5-MTHF first for MTHFR variants. Common co-occurring problems: PTSD (the dissociation and analgesia buffered trauma, so trauma treatment runs alongside); ADHD; nicotine (wet is usually smoked on tobacco), where bupropion is one option, but because CYP2B6 also handles bupropion, metabolizer status changes its dosing; and cannabis, if that was the base.

How to be taken seriously: PCP is poorly known, even among addiction specialists. The Kernel suggests saying plainly that you have a history of phencyclidine use disorder, that PCP has NMDA, dopamine, sigma-1, and anticholinergic effects, that you may be a CYP2B6 poor metabolizer from how it hit you, what symptoms you have now, and that you are requesting CYP2B6 and CYP3A4 testing, a cognitive evaluation, and psychosis, sleep, or other management as needed.

Turn to: Supp. Ch. 25 §3.2 (having the physician conversation), §3.3 (no FDA-approved MAT for PCP), and §8.2 (co-occurring conditions). Compendium Protocol 13 (The Pharma Trap). Supp. Ch. 39 (Complex Trauma and the Substance Connection).

Step 9 — The community and structural picture (Months 1–12+)

The Kernel places PCP in a specific history: its epidemic periods hit urban, lower-income, predominantly Black communities hardest, including in Los Angeles, Washington DC, Philadelphia, and Detroit, and it says the response favored enforcement over medicine, with almost no PCP-specific treatment and little attention to the cognitive aftermath that affects work and recovery itself. Its position: the person who developed this use in conditions of poverty and inadequate treatment was failed by systems, not by their constitution. The practical parts: structural supports (housing, work, legal aid where needed, as in the crack guide), peer recovery support and community service, which it calls especially meaningful here, and a recovery community rebuilt away from the conditioned unit of people, place, and substance. Full Inventory is a structured 180-day plan, and Amends to Self puts the person who lived through it first.

Turn to: Supp. Ch. 25 §8.1 (the community dimension). Supp. Ch. 13 §8 (the crack cocaine chapter's criminal-justice and community resources, which the Kernel says apply). Supp. Ch. 42 (Full Inventory). Supp. Ch. 43 (Amends to Self). Compendium Protocol 24 (Returning to Work), Protocol 22 (The Family Field), Protocol 16 (The Isolation Spiral), Protocol 25 (The Open Door). Supp. Ch. 51 (Family & Support Network Guide): give it to the people who love you.

Step 10 — The long game (Months 6+, Year 1 to Year 10)

The Kernel calls PCP recovery long-game work because of the cognitive dimension: the person at 12 months with rebuilt prefrontal function, both natural architectures running, and the memory system recovering has access to a clarity that PCP only approximated by blocking receptors, and "the real thing is clearer." It closes: the clarity was real, the instrument was borrowed, and recovery is owning it directly, without interest paid in psychosis. Navigation after the first year shifts from repair to stewardship. Section 4 shows how. Standing tools: Supp. Ch. 44 (The Transplant: redirect the devotion and daily structure the pattern required into a practice that grows). Supp. Ch. 6 (Stay Non-Addicted) and Compendium Protocol 02 (Behavioral Addictions, with its "Mask Change" caution on addiction transfer). Compendium Protocol 13 (The Pharma Trap). Supp. Ch. 38. Supp. Ch. 5, Step 6 (a weekly AI check-in profile, a reasoning tool and never a provider).

Turn to: Supp. Ch. 25 §7 (the protocol map: cognitive recovery; community and long game). Centurian Paper C-28 (The Recast). Compendium Protocol 25 (The Open Door), Protocol 20 (Mapping the Terrain).

4. How navigation changes at Years 3, 5, and 10

Shading shows how much attention each track needs. Darkest is primary focus, then active, then maintenance. White cells with gray text are standing safeguards: low effort, never dropped. Numbers in brackets refer to the shifts listed below the table. The Kernel's PCP timeline ends at about 12 months, so later years are projection.

Track	Months 0–24 (foundation)	Year 3 (consolidate)	Year 5 (build out)	Year 10 (steward)
Safety and psychiatric	Psychosis plan; sleep first	Psychosis watch; meds reviewed [1]	Annual check; sleep, mood	PCP named to every clinician [7]
Biology and genome	CYP2B6, CYP3A4; COMT, DRD2	Retest labs; step stack to upkeep [2]	Prescriber card: CYP2B6 status	Re-check with new meds and age
Cues and context	Wet cues out; smell, places	Cues fainter; plan ready	Triggers shift: pain, loss [5]	Same plan, rehearsed
Dissociative escape practice	NSDR, meditation; pain plan	Practice deepens; awe, nature	Daily practice, pain plan held	Practice as a way of life
Stimulant intensity	Intensity first: sprints, sport	Competition and craft carry the load [3]	Several intense outlets	Intensity outlets, still weekly
Cognition and memory repair	Cognition slow; exercise, practice	Memory and focus rebuilt [4]	Keep learning; keep moving	Cognition steady; checks as needed
Community and Manning	Community first; structure, safety	Transplant; return to work	Manning: peer recovery work [6]	Mentor or run a group

The seven shifts

1. **Year 3, the psychosis watch and medication review.** The Kernel says persisting psychosis beyond about six weeks of full abstinence needs evaluation for an independent psychotic disorder (Supp. Ch. 25 §3.1). By year 3, keep a standing psychiatric relationship if you ever had prolonged psychosis, review any antipsychotic or sleep medication with the standard in Compendium Protocol 13, and report any new perceptual symptoms early.
2. **Year 3, the stack moves from building to upkeep.** The Kernel places heavy-use cognitive recovery at 6 to 12 months (Supp. Ch. 25 §7). Retest labs (Supp. Ch. 5 Step 1a) and step down toward maintenance. The Trinity chapter says supplements are taken until stable, then tapered and resumed if the system destabilizes; Main Book Ch. 2 treats MTHFR support as maintenance, not cure. Step down to maintenance, not to zero.
3. **Year 3, competition and craft carry the load.** The Kernel's stimulant track (competition, mastery, and service) is meant to be ordinary life, not a bridge (Supp. Ch. 25 §6). Keep several outlets, since a DRD2 A1 profile is fragile with one source of reward.

4. **Year 3, memory and focus are rebuilt.** The Kernel says the cholinergic and prefrontal repair takes months to a year for heavy use, and grows with practice (Supp. Ch. 25 §6, §7). By year 3, what you can hold in mind and sustain should be back or close, and the memory practices can become ordinary hobbies.
5. **Year 5, triggers shift to pain and loss.** The Kernel names pain and the flat or overwhelming state as recurring triggers (Supp. Ch. 25 §5). As smell and place cues fade, keep the pain plan current and your people close. This shift is partly sourced and partly extrapolation.
6. **Year 5, Manning.** This is the Trinity's third stage (Supp. Ch. 2). The Kernel calls peer recovery and community service especially meaningful for people from communities the treatment system failed (Supp. Ch. 25 §6).
7. **Year 10, name PCP to every clinician.** CYP2B6 status affects bupropion, efavirenz, and other drugs, and prolonged PCP psychosis is easily misread as primary psychosis (Supp. Ch. 25 §1.3, §3.2). Keep your result on your card and your history on file.

What is sourced and what is extrapolated. *Shifts 1, 3, 6, and 7 rest directly on Kernel text. Shifts 2 and 4 apply Kernel rules at a timing chosen for this guide. Shift 5 is partly extrapolation. The Kernel's PCP timeline ends at about 12 months.*

5. What outcome to expect

The short version

The Kernel has no PCP case study and gives no 12-month percentages, so this section is qualitative and does not make up numbers. If you do the route above, with the psychiatric care first, CYP2B6 known, the triple foundation built, the dual craving handled, and both natural architectures and the memory track built, this is what the Kernel supports:

- **Psychosis is treated, not waited out.** Most PCP psychosis clears substantially within 2 to 6 weeks of abstinence with sleep and treatment, longer in poor CYP2B6 metabolizers, and persistent psychosis is evaluated.
- **Negative symptoms lift with time and rebuilding.** Blunting and low motivation improve with exercise, BDNF-building, and the dopamine stack, with ongoing support where needed.
- **Cognition returns slowly.** For heavy use, roughly 6 to 12 months of explicit work for significant improvement in memory, attention, and executive function.
- **By years 3 to 5 the work is maintenance and building. By year 10 you are a steward,** carrying a small set of standing safeguards.

The Kernel does not promise zero risk. It says PCP psychosis can persist, that PCP can re-emerge from fat stores, and that some heavy users carry a persistent deficit state after psychosis resolves.

Milestones, in order

Milestone	When	Expected outcome	Source	Basis
Safe start	Days 0–14	Emergency plan known. Psychiatric evaluation if psychosis persists beyond 48 hours. Sleep prioritized. Temperature and heart watched.	Supp. Ch. 25 §§0, 3, 7	Clinical fact
Acute intoxication	Hours to about 8	Primary effects last roughly 4–8 hours. Residual psychotic features can last days to weeks.	Supp. Ch. 25 §1.2	Clinical timeline
Psychosis window	Weeks 2–6	Most PCP psychosis clears substantially within 2–6 weeks with sleep, treatment, and abstinence. Poor CYP2B6 metabolizers may take longer.	Supp. Ch. 25 §3.1	Kernel projection
Independent-disorder check	Beyond about 6 weeks of abstinence	If psychosis persists, evaluate for a separate psychotic disorder.	Supp. Ch. 25 §3.1	Kernel projection
Fat-stored PCP	Days to weeks after use; drug-test positives up to 4–6 weeks	Release from fat during exercise, fasting, or illness can bring back symptoms. Test positives last about a week (occasional) to 30+ days (heavy).	Supp. Ch. 25 §1.5	Kernel projection
Cognitive recovery	Months 3–12	Significant improvement in memory, attention, and executive function with exercise and practice, roughly 6–12 months for heavy use.	Supp. Ch. 25 §7	Kernel projection
Deep-root reversal	2–5+ years (heavy long-term use)	Prefrontal recovery and epigenetic reversal continue. Some changes may be partial.	Supp. Ch. 36	Kernel projection
Steward phase	Years 3–10	Repair tracks at maintenance. Both natural architectures running. Peer work. Standing safeguards.	Section 4 of this guide	Extrapolated

The Kernel's 12-month numbers: none for PCP

The Kernel has no PCP case study and gives no PCP-specific projection, so there is no 12-month table here, and this guide will not make one up. The nearest profiles in Supplemental Chapter 2 are Case 09 (ketamine, an NMDA and trauma profile) and Case 04 (cocaine, a Warrior stimulant profile), and neither is a prediction for PCP. What the Kernel does offer is the timeline above.

What changes the outcome

- **Treating psychosis as "still high."** The Kernel says prolonged PCP psychosis needs psychiatric care, and each untreated day carries risk.
- **Restraining or arguing with an intoxicated person.** Call 911, reduce stimulation, and keep space and safety.

- **Not knowing CYP2B6.** It explains the severity, and it changes several future prescriptions.
- **A misdiagnosis.** PCP psychosis labeled as schizophrenia, or its negative symptoms labeled as depression and treated with an antidepressant alone.
- **Starting stimulating supplements during active psychosis.**
- **Only one architecture.** The Kernel says an escape practice without an intensity outlet, or the reverse, leaves half the pull unaddressed.
- **Ignoring the memory and attention damage.** It affects work and the ability to engage with recovery.
- **The wet cues and the conditioned unit** of person, place, and substance left intact.
- **Using more to smooth out the residue.** The Kernel says it prolongs it.
- **A lapse.** The Kernel treats it as information, not judgment (Protocol 21). It is also a psychiatric-emergency risk: do not use alone, and get urgent help for agitation, confusion, or psychosis.

How to read the evidence behind the outcomes

The Main Book marks claims with an Evidence Tier: Established, Probable, Emerging, Author/System Experience, and Controversial or Mixed. This guide's reading: the emergency picture (nystagmus, analgesia, agitation, psychosis, hyperthermia), the danger of forceful restraint, PCP's long-standing use as a model of psychosis, and its long psychotic aftermath are well established clinically. The Kernel's CYP2B6 "logjam" is plausible but, as I understand it, the evidence for PCP specifically is thinner than for ketamine, and its claim that fat-stored PCP re-emerges weeks later is a reasonable hypothesis rather than a settled fact. The Kernel's statement that one reagent identifies PCP by a specific color is not something I could confirm. The supplement stack, the acetylcholine track, the peptide layer, and the years 3 to 10 trajectory sit lower on that scale, so bring them to your clinician as questions, not as facts. The community history is the Kernel's account and is offered here as its framing.

Take these to your clinician

- An honest account of your use: the form (wet cigarettes, powder, liquid), how often, how long, and any other substances, so psychosis risk and interactions can be judged. Name PCP specifically.
- Any psychotic symptoms and how long they lasted, any family history of psychosis, and any new perceptual symptoms since stopping.
- A request for CYP2B6 and CYP3A4 testing, and every medication and supplement you take, since some (fluconazole, some antibiotics, some HIV drugs) slow clearance.
- Sleep, mood, and memory problems described specifically, and a request for a cognitive evaluation if fog or memory trouble persists.
- Questions about co-occurring PTSD, ADHD, nicotine (and how CYP2B6 affects bupropion), and cannabis, and about peer recovery and community resources.